Name:
Chart:
Date:

Midwest Orthopedic Specialists

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AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient Name: ____________________ Date of Birth: ____________________
Address: ____________________ SSN: ____________________

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual /organization is authorized to make the disclosure (organization to release the records):

   ____

3. The type of information to be used or disclosed is as follows (request only the information you want released)

   All medical records from your facility. Only records from ________ to ________ .

   Consult Notes Operative reports

   Testing and/or lab results (describe the dates or type of tests you would like disclosed): ____________________

   X-rays and/or other imaging films (please describe the dates or types of x-ray or images you would like disclosed): ____________________

   Other (please describe): ____________________

   Medical Information only Financial Information only Medical and Financial Information

   Verbal only Written only Verbal and Written

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome(AIDS), or human immunodeficiency virus(HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and Abuse. 8-18-42 308- 625.3

5. The information identified above may be used by or disclosed to the following individual/organization:
   (To whom are the records being released. — If family, list name and relationship)

Name: ____________________ Records needed by date ____________________

Address: ____________________ To be mailed (✓) ____________________

____

____________________ To be faxed (✓) ____________________

Phone: ____________________ To be picked up (✓) ____________________

Fax: ____________________ Date to be picked up ____________________

Processed by ____________ Date ____________

BC4

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6. The information will be used for the following purpose (check as many as applicable):

- ☐ My personal records
- ☐ Attorney
- ☐ Disability Claim
- ☐ Insurance Company
- ☐ Social Service Agency
- ☐ Relocation of self of family
- ☐ Second opinion (as recommended by my physician)
- ☐ Second opinion (as preferred by patient)
- ☐ Referred to specialist
- ☐ Transfer of care
- ☐ Other (please describe) ______________________________

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8. This authorization will expire (insert date or event): ______________________________.
If I fail to specify an expiration date/event, this authorization will expire 1 year from the date it was signed.

9. I understand that once the information is disclosed, it may be re-disclosed by the recipient, and federal privacy laws or regulations may not protect the information.

10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

______________________________ ______________________________

Signature of patient or legal representative (must be 18 or older) Date

If signed by legal representative, relationship to patient ______________________________

______________________________ ______________________________

Signature of Witness Date

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OFFICE USE ONLY:

Chart # ______________ Date Rec'd ______________ Date Sent ______________ By (staff) ______________

Copy of form provided to patient? ☐ Y ☐ N

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